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BUSH ADMINISTRATION'S MEDICAID REFORM PROPOSAL

This memorandum is to provide you with a report with recommendations on the Bush Administration's Medicaid reform proposal pursuant to your Board's order of February 11, 2003. This proposal, named "State Health Care Partnership Allotments," covers the State Children's Health Insurance Program (SCHIP) as well as Medicaid. It seeks to provide states with relief from rising health costs and greater program flexibility.

EXECUTIVE SUMMARY

The Administration proposes to give states the option to receive greater flexibility over Medicaid and SCHIP in exchange for having their Federal funding capped for ten years. The increased flexibility includes allowing a state to spend less on Medicaid and SCHIP than under current law. In participating states, Medicaid no longer would be an open-ended entitlement in which Federal Medicaid payments automatically match state Medicaid cost increases.

We believe the County would be better off if the State did not receive Medicaid funding through the new block grant option. In the proposal's current form, there most likely would be less Federal and State Medicaid revenue available to provide medical care to

County residents. California's Federal funding over the next ten years would be based on its Federal Fiscal Year 2002 funding level when it received the least amount for Federal Medicaid funding per recipient of any state. It also would make it more difficult for the County to extend its current Medicaid demonstration project or secure future fiscal relief. This is because the County's health care system would be competing with other health providers and parts of the State for a limited and shrinking pot of health care funds.

The Administration's goals of providing states with fiscal relief and greater program flexibility are consistent with goals and policies included in the Federal Agenda adopted by your Board on February 4, 2003. However, revisions are needed to ensure that the reforms would benefit the County and be consistent with existing Board policies. Most notably, Medicaid should remain an open-ended entitlement. Both fiscal relief and greater flexibility can be achieved without capping Federal and State Medicaid funding.

Below is a detailed analysis of the Administration's proposal followed by Medicaid and SCHIP recommendations that are consistent with existing Board policies.

CURRENT LAW

Under current law, Medicaid (Medi-Cal in California) is an open-ended entitlement program providing medical assistance to eligible low-income persons. The Federal government provides matching funds, ranging from 50 percent to 83 percent, based on a state's per capita income. States with high per capita incomes (e.g., California) have the minimum Federal match rate of 50 percent. Each state designs its Medicaid program within Federal guidelines that require certain groups (e.g., foster children) and basic services (e.g., hospital care) to be covered. States may cover other optional groups and provide up to 34 optional services (e.g., clinic services). As an open-ended entitlement, Federal Medicaid payments automatically match non-Federal Medicaid expenditures, including when a state increases its Medicaid eligibility, benefits, or provider reimbursement rates.

SCHIP (Healthy Families in California) helps states to provide health coverage to children with family incomes too high to qualify for Medicaid. Each state receives a fixed annual SCHIP allotment that must be spent within three fiscal years. The Federal match rate for SCHIP, which varies based on state per capita income, is higher than Medicaid. California's SCHIP match rate is the Federal minimum rate of 65 percent.

In addition, current law authorizes states to seek budget neutral Federal waivers of Medicaid and/or SCHIP program requirements, allowing them to expand eligibility or covered services and to contain program costs.

ADMINISTRATION'S REFORM PROPOSAL

The Administration's proposal would provide states with the option of receiving greater flexibility over the use of Medicaid and SCHIP funds in exchange for having their Federal funding capped over a ten-year period. Medicaid, therefore, no longer would be an open-ended entitlement in states which select this option. Key elements of the proposed state option include:

- Participating states would receive two annual allotments – one for acute care and one for long-term care. States may transfer up to 10 percent of funds between the two accounts, and may use up to 15 percent of their allotments for administration and Disproportionate Share Hospital (DSH) payments.

- A state's ten-year funding would equal the estimated amount that it otherwise would receive under current law. Annual allotments would be based on the amount of Medicaid and SCHIP funds received by a state in Federal Fiscal Year (FFY) 2002, adjusted for the impact of statutory and other program changes and for a pre-set growth rate, which has not yet been defined. The Administration assumes that Medicaid spending nationally will grow by an annual average of nine percent over the next ten years, but has not indicated how an individual state's growth rate would be calculated.

- As a financial incentive, an estimated combined total of $3.25 billion in extra funds would be provided to participating states in FFY 2004 and $12.7 billion over the first seven years. To maintain budget neutrality, allotments to participating states would be reduced by $12.7 billion in the final three years of the ten-year period.

- Instead of requiring state matching funds, a state would have a maintenance-of-effort (MOE) requirement tied to its FFY 2002 Medicaid and SCHIP spending level, adjusted annually for changes in the medical consumer price index (CPI).

- States would be required to maintain eligibility for current mandatory beneficiary groups, but would be granted greater flexibility in setting eligibility, covered benefits, and cost-sharing requirements. States would not have to provide a uniform set of benefits to beneficiaries, and benefits and eligibility requirements also could vary geographically within a state.

- Once a state exercises its option to receive a block grant, it cannot opt out during the ten-year period.

The Administration's proposal must be authorized by statute. The Administration has not released a detailed proposal that goes beyond the basic elements outlined above. In part, this is because it has not decided its position on some key issues, such as the full extent of state flexibility under the block grant option. For example, at the recent National Association of Counties Legislative Conference, Dennis Smith, who directs the Center for Medicaid and State Operations, indicated that the Administration has not decided whether states would be allowed to extend eligibility to categories of non-citizens who are ineligible for Medicaid under current law.

POTENTIAL IMPACT OF THE ADMINISTRATION'S PROPOSAL

The Administration's reform proposal would not affect the County and its residents unless California were to exercise the new block grant option. We believe that the County would be better off if the State did not elect to receive a block grant. This is because the likely net loss of Medicaid revenue available to provide medical care to County residents would far outweigh any potential benefits that could result from increased program flexibility.

California Federal Funding Would Be Capped at Low Level

Under the block grant option, California's Medicaid funding would be capped and based on the State's current unfavorable Medicaid funding base for a ten-year period. That is, California's block grant allotments would be tied to its Medicaid funding in FFY 2002 when it received the least Medicaid funding per recipient of any state. Even worse, its future annual allotments would be adjusted downward to take into account the reduced amount of Federal funding it would receive under current law due to the Medicaid DSH cut that took effect in FFY 2003, the State's lower upper payment limit (UPL) for public hospitals, and the phase-out of the County's 1115 Medicaid waiver.

The fact that California receives the least Federal Medicaid funding per recipient of any state also means that greater program flexibility is less valuable to California than to states which receive far more funds per recipient. For example, New York, which receives the most Medicaid funds per recipient, can greatly expand Medicaid eligibility to triple its Medicaid recipient population and still would be spending more per recipient than California. Our State, however, cannot expand eligibility without spending an even smaller amount per recipient than other states.

California Could Receive More Federal Funding Under Current Law

By accepting the block grant option for ten years, California would lose the opportunity to receive far more Federal revenue under current law, which does not limit the amount

of Federal Medicaid matching funds that a state may receive. California receives less Medicaid funds per recipient than any other state, in part, because it puts up relatively little non-Federal matching funds. The current State budget deficit limits the State's ability to increase its General Fund Medi-Cal expenditures. However, California can increase its Federal revenue at no expense to its General Fund by making greater use of other allowable non-Federal matching funds, just as other states do and as the State did during the State budget crises of the 1990s when it began using intergovernmental transfers (IGTs) as matching funds.

California still can expand its use of IGTs to secure more Medicaid matching funds. However, the biggest untapped source of non-Federal matching funds which is used by other states, such as New York, is revenue from fees imposed on private health providers. Similar to how California uses IGTs to draw down more Federal funds which, in turn, are used to increase reimbursement rates for providers, including the public entities that make IGTs, fees on private health providers are used to secure more Federal revenue and increase provider reimbursement rates.

It is noteworthy that the disproportionate share hospital (DSH) cap and upper payment limit (UPL) problems facing California's public hospitals could be eliminated if fees were imposed on private hospitals to help finance DSH and SB 1255 supplemental hospital payments. Under current State law, IGTs finance all DSH and SB 1255 payments to private as well as public hospitals. In many other states, provider fees are used to help finance not only DSH payments, but also nursing home and other Medicaid costs.

State Medi-Cal Funding Would Be Less Than Current Law

The risk of reduced State Medi-Cal funding under the block grant option is even greater than the risk of reduced Federal funding. This is because the Administration's proposal mainly provides fiscal relief to states by allowing them to spend far less on Medicaid. Instead of having to provide matching funds, a participating state would have a maintenance-of-effort (MOE) requirement tied to its FFY 2002 Medicaid/SCHIP spending level, adjusted for changes in the medical consumer price index (CPI).

During the past ten years, Medicaid expenditures have grown more than twice as fast as the medical CPI, which has grown at an average annual rate of 4.1 percent. Because, under current law, it is highly likely that the State's Medi-Cal expenditures would continue to grow at a far faster rate than the medical-CPI, the proposed MOE requirement would allow the State to spend far less on Medi-Cal than it otherwise would spend over the next ten years. There is little reason to believe that the State would spend more than the minimum MOE on Medi-Cal, especially when the State has revenue shortfalls.

State Could Shift Non-Federal Medi-Cal Costs to Counties

Moreover, the State would be able to shift a greater share of non-Federal Medi-Cal costs to counties, especially for long-term care. The State's Medicaid long-term care costs consist mainly of nursing home and In-Home Supportive Services (IHSS) costs. The State finances all non-Federal nursing home costs, but only 35 percent of IHSS costs. The State can shift a greater share of long-term care costs to counties by simply spending more of its Federal long-term care allotment on nursing homes. It also would have greater freedom to implement policies that discourage nursing home placements and encourage in-home care. The county share of IHSS costs as well as county IGTs for MediCal hospital payments would count toward the State's MOE requirement.

Moreover, instead of using its flexibility under the block grant to expand eligibility or increase provider reimbursement rates, the State could exercise its flexibility to use Federal funds to cover current State-funded health services that currently are ineligible for Medicaid reimbursement. Moreover, to the extent that such services become eligible, the State also could meet its MOE requirement by counting its General Fund expenditures on such services. In sum, under the block grant option, the County could face a major loss of Federal and State Medicaid revenue over the next ten years.

Future Fiscal Relief For County's Health System Would Be Jeopardized

It is noteworthy that the block grant option, in effect, would make Medi-Cal financing a "zero-sum game" in which both Federal and State funding would be capped. This means that the County's health care system would be competing with other health providers and other parts of the State for limited health care funding. In fact, to the extent that the new MOE requirement will allow the State to spend less on Medi-Cal, the County could be competing for a shrinking pot of funds. This undoubtedly will make it more difficult for the County to extend its current Medicaid demonstration project or secure fiscal relief in the future.

RECOMMENDATIONS BASED ON EXISTING BOARD POLICIES

The Administration's Medicaid/SCHIP proposal's goals of providing states with fiscal relief and greater program flexibility are consistent with legislative goals and policies included in the Federal Agenda adopted by your Board on February 4, 2003. Revisions, however, are needed to ensure that the Medicaid and SCHIP reforms would benefit the County and be consistent with existing Board policies. Most notably, the proposal should be revised to maintain Medicaid as an open-ended entitlement. Both fiscal relief and greater flexibility can be provided without capping Federal and State Medicaid funding as proposed under the Administration's block grant option.

Recommendations for Providing Fiscal Relief

Based on existing Board policies, the County would recommend the following alternative approaches for providing California and the County with fiscal relief without ending the current open-ended Medicaid entitlement:

- **Medicaid Disproportionate Share Hospital (DSH) Funding:** Medicaid DSH funding to states, which was cut beginning in FFY 2003, should be restored. This would prevent an annual loss of about $184 million in DSH funding to California.

- **Temporary Federal Medicaid Match Rate ("FMAP") Increase:** States should be required to continue to provide non-Federal matching funds, but the FMAP should be increased for FFY 2004 to help states which now face major budget deficits. Unlike the Federal government, states annually must balance their budgets. Federal Medicaid funding is needed the most when the economy is weak.

- **Calculation of Federal FMAP:** The methodology for calculating a state's FMAP should be made more equitable by taking into account a state's poverty rate, as recommended by the General Accounting Office. Under current law, the Federal Medicaid match rate (FMAP) ranges from 50 percent to 83 percent, based on a state's per capita income. Because California has a relatively high per capita income, the State's FMAP is only 50 percent even though its poverty rate is higher than two-thirds of all states. The poverty rate is a more accurate indicator of the relative need for Medicaid services than per capita income. Increasing California's FMAP would bring the State's Federal Medicaid funding per recipient closer to the national average.

- **Undocumented Immigrant Emergency Medical Costs:** State and local governments should be fully reimbursed for the cost of emergency medical care provided to undocumented immigrants who are in the country due to the Federal government's inability to control illegal immigration. California and the County would disproportionately benefit from such reimbursement.

Recommendations for Increasing Flexibility

Based on existing Board policies, the County would recommend the following reforms that would provide greater flexibility under the Medicaid and SCHIP programs:

- **Eligibility:** States should be allowed to extend Medicaid eligibility to more persons, especially the uninsured and minors whose health needs, otherwise, must be met by the County.

- **Providers/Services:** States should be provided greater flexibility over the scope and delivery of Medicaid services. For example, states should be allowed the options to cover the evaluation and diagnosis of learning disabilities and to provide care to patients in institutions for mental diseases (IMDs). States also should be allowed to make Medicaid payments to In-Home Supportive Service (IHSS) providers who are responsible relatives of recipients.

- **Payments:** States should be allowed to make Medicaid payments to providers in a manner that encourages the more efficient use of resources and the expansion of ambulatory care. For example, states should be granted the flexibility to make DSH payments to health safety net providers in a manner that removes the current financial incentive to provide inpatient hospital care even when ambulatory care is more appropriate and less costly.

- **SCHIP:** States should be provided more flexible use of SCHIP funds, including the ability to expand eligibility to cover parents and legal immigrants, expand the scope of covered services, and use community-based delivery systems. States also should be allowed to retain their SCHIP allotments for more than three fiscal years.

- **Waivers:** States should be given the option of securing greater Medicaid and SCHIP flexibility through the use of budget neutral waivers that do not impose a pre-set limit on Federal funding a state may receive during the waiver period. There should be greater flexibility over the duration of waivers, which currently are limited to no more than five years. The waiver process also should be equitable for all states. A requirement that has been waived in one state should be waivable in all states, and any method for computing budget neutrality that has been approved for one state's waiver should be allowable for other states' waivers.

We will keep your Board apprised of any major new developments.

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c: Executive Officer, Board of Supervisors
County Counsel
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